



# *The Repetition & Avoidance Quarterly*

Volume Nine, Number Two

The Washington State Veterans PTSD Program

Fall, 2004

## VA Sponsors Northwest PTSD “Summit” for Care of Returning Iraq and Afghanistan War Veterans

In the past few months we have witnessed some remarkable events occurring in response to war. These largely *organizational rebooting* activities have led me to wonder once again about that perennial question, does significant change happen due to “great times” or due to a “great person?” I wrote about these cultural changes in the last edition of the *RAQ*. Three months later, I am still modestly startled when I think about the pervasive desire and effort seen among so many mental health professionals of Washington State to create a healthier homecoming for returning veterans. I am certain that much of this positive energy is driven by the difficulty of working with so many veterans of other wars—veterans who have taken years to finally come for care, and when they do, present with very complicated forms of war trauma PTSD.

The people behind the current movement for a concerted outreach and treatment effort on behalf of OIF and OEF returnees, are not only mental health staff and contract providers within county, state, and federal government. Included are many Vietnam War veterans, parents, and others willing to assist war returnees as they embark upon their journey home. It is as though the *collective gash* in the human spirit left by the residuals of earlier wars has gathered us together for the common good and health of war survivors. An activism that is borne out of the collective *knowing* of undisclosed and distressing secrets about the psychological affects of war, has compelled people to become “great persons” making a path to a better homecoming.

### **VA VISN 20 Sponsors PTSD Summit**

On 8 and 9 November 2004 evidence of having some of these “great persons” in our area could be found when approximately sixty-five people gathered on the north shore of the Columbia River in Vancouver, WA. This was a VISN (Veteran Integrated Service Network) 20 sponsored event, designed to encourage the exchange of information among all providers within the four state area (Alaska, Idaho, Oregon, and Washington). This Summit included VA treatment

program heads within the VA Medical Centers and VA RCS Vet Centers within the VISN 20 catchment area. In smaller numbers were the Departments of Veterans Affairs of each of the four states, military reserve and National Guard family support units, as well as TriWest (TriCare) representatives. Les Berger, Chief of VISN 20, led off the event with opening remarks that were praiseworthy of everyone’s efforts. He was particularly complimentary of the work being done in Washington among VAMC, Vet Centers, WDVA, and the Washington State National Guard and reserve units. He noted that these efforts represented work unlike anything else in the country— “...a model for others to emulate.” (See story of the MOU signing event - page 2.)

### **Expected Mental Health Problems Described**

Day one of the conference was filled with short, tightly packed presentations that alerted participants to the significant potential for mental health problems among OIF and OEF returnees, and the likely clinical presentation that we will continue to see among returnees.. Jim Sardo did a particularly good job (again) of offering his personal field experience in the war theater as a MASH-like unit psychologist. Michael Cole offered a his own version of this experience as an army psychiatrist. Both presentations offered moments of Hawkeye Pierce-like humor, no doubt a psychological buffering device offering some cushion to the stark realities of life at a field medical triage and treatment unit. Other presentations reviewed the latest efforts at Madigan Army Medical Center, the liaison and joint treatment triage work with the VA, and an update on the post deployment health screens that will be completed as soldiers return.

Insight into the organizational structure of the National Guard and military reserves offered attendees a chance to better understand how linkage to counseling and other services will occur for returning individual veterans, and the importance of the family support network and home-front stability. Members of deployed National Guard units from Oregon kept the proceedings honest, with real world accounts of events gone-well, and those occasions that were sometimes amiss.

(Continued on page 3, see *Returnee preparations*.)

## *State and Federal Leaders Sign a Pledge of Commitment to Serve National Guard & Reservists Returning from War*



Poised to sign the Memorandum of Understanding are, in foreground right to left: Major General Timothy J. Lowenbert, The Adjutant General, Director, Military Department; John M. King, Director Washington Department of Veterans Affairs, Dr. Sylvia P. Munday, Commissioner, Employment Security Department, Thomas E. Pearson, WA State Director, Veterans' Employment and Training Service U.S. Department of Labor, Leslie M. Burger, MD, FACP, Network Director, VISN 20 Department of Veterans Affairs, Kristine A. Arnold, Director, Regional Office Department of Veterans Affairs, Don C. Brunell, President, Association of Washington Business, and Richard L. Marin, Chairman, Governor's Veterans Affairs Advisory Committee.

On November 5, 2004, a Memorandum of Understanding was signed by state, federal and local partners pledging their commitment to service our state's returning National Guard and Reserve soldiers. Hope was expressed that the agreement will enhance transition services already available to returning soldiers through the federal government by focusing on "after active duty" support to the thousands of members of the Washington National Guard mobilized for Operation Iraqi Freedom and Operation Enduring Freedom.

WDVA led the effort to bring these partners together from the Washington National Guard, Washington Employment Security Department, U.S. Department of Veterans Affairs, U.S. Department of Labor, Association of Washington Business, and the Governor's Veterans Affairs Advisory Committee.

A committee of representatives from each of these groups, plus representatives of other veteran organizations, worked together to identify how they can best serve the needs of returning soldiers. "This partnership will provide an opportunity to stay in touch with these young men and women at critical intervals, as well as letting them know the State of Washington appreciates their sacrifice and stands ready to provide assistance to them and their families," said WDVA Director John King.

The memorandum outlines family support services, a plan for Washington's Armories to be "adopted" by veterans organizations, and identifies mental health services available for both the soldiers and their families. ##

(*Returnee Preparations*, continued from page 1.)

The roles played by the RCS Vet Centers and WDVA PTSD Program were given a significant amount of time to explain the special services offered within these unique venues, and how the VA Medical Center programs act in a connective role in the overall health care of each returning veteran. This theme of collaboration on behalf of veterans continued into the afternoon with presentations of three examples of successful “working-together”. The role of TriWest spontaneously became evident as a critical element, and fleet-of-foot organizer Jim Boehnlein, quickly offered space in the agenda to fully explore the intricacies of this government offered health care insurance program.

The afternoon of the first day started by herding participants into geographically organized breakout sessions—opportunities for sharing ideas, examining local treatment access policy, and the state of current collaboration. This element of the Summit was invaluable in that historical encumbrances to veteran care were identified and compared with the Summit’s implied objectives to reduce barriers to care. It was observed by this participant that some issues of locally devised policy were being rethought as the conference progressed, even though there were no first-day directives promoted by VISN leadership.

On the second day breakout sessions, composed of randomly assigned players, labored with more clearly assigned tasks. These objectives included: Create models of care that promote service availability; Improvement speedy access to care, Create specific outreach; Develop service network communication habits, Formulate ideas for continued planning and action among participants; And, promote the evolution of leadership from within and between the programs and regions. Summaries of breakout session notes were reported to the larger group, and will be shared in written form with all participants. These hopefully will result in a second summit, or may lead to regional gatherings to address specific local policy and activities.

#### **Conference Results**

Since the conference I have come to be aware of at least four things that merit note here. The first observation has been the significant energy among VA staff to obtain nationally offered grant funding for specialized services to address the expected wave of service needs. I know of two grant applications, one in Western, and another in Eastern Washington, focusing upon outreach, referral, and direct mental health service delivery.

The second set of immediate results of the VISN PTSD Summit was the interest in the WDVA PTSD Program. At the time of this writing calls have been received from Oregon, Alaska, and California asking for assistance with respect to starting state-funded war trauma and/or PTSD outpatient treatment programs. In recent days I have spent time with State of California legislative members and policy staffers crafting both policy and legislation aimed at placing a PTSD Program into California State statute.

I was also surprised to learn that the State of New Jersey has a state-funded PTSD program, offering outpatient care for the past 10 years. The New Jersey official with whom I spoke, expects an estimated 2,100 veterans to seek care in the first four years as a result of OIF and OEF. He learned of Washington’s Program from a member of the VISN 20 Summit event.

The third impact of the Summit has been the flurry of activity

taking place to address the needs of the National Guard Family Support System.. Conference calls and hastily convened work sessions are preparing standardized information for all events offering support and referral to the National Guard Family Support members, and to returnees upon their homecoming.

#### **Vietnam War Veterans Volunteers**

The fourth remarkable thing that has happened since the VISN PTSD Summit, has been the number of Vietnam War veterans, family members, and others who have been seeking ways to connect with OIF and OEF returnees. While less likely directly the result of the Summit, these veterans with whom I have had contact are all saying essentially the same thing: “How can I get involved to help these men and women return home?” In my view, the request to help, in and of itself, represents not *just* evidence of heart warming compassion and empathy, but *wisdom* about the nature and affects of war. War veterans seeking to help veterans of another war era is indeed moving, and marks the result of hard work in therapy and personal mastery of a plethora of complex feelings, urges, desires, and fears.

The telephone calls of these volunteers evoke memories of Vietnam War veteran homecomings and the nation’s response. The failure of the “homecoming” for Vietnam War veterans deepened the already harsh war wounds. Fathers and Vietnam War veteran sons frequently experienced life-long rifts because of a failed homecoming. Some of these fathers died before their Vietnam War veteran sons and daughters could talk with them about each other’s war. It is my recollection during Operation Desert Storm, that Vietnam War veterans, in some instances, rejected the experience of Gulf War veterans. However, the current war in Iraq carries so many features of the Vietnam War—its lack of defined ending points, the likelihood of going into many extra innings and multiple tours, the inability to determine friend from foe, locals who move from ‘good guy’ by day to ‘bad guy’ by night, and the use of women and children as tactical weapons in the psychology of combat. Many Vietnam War veterans define this as war at its psychological worst. Yet, these features are acting to create a special linkage with OIF and OEF combatants in the process.

The new and even exciting difference, thanks to events such as the PTSD Summit, means that issues such as a volunteer wanting to help fellow war veterans, may be considered by many well placed professionals at once. Collective consideration of peer support or other ideas may come just in time for helpful connections to occur as OIF/OEF returnees find themselves at home, searching for answers, and seeking their prewar lives. ts ##

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### ***New York Times Reports Impact of Returning War Veterans***

NY Times reporter Scott Shane wrote in the 12/16/2004 edition that the VA health care system was hard pressed to cope with the anticipated “deluge” of returnees with PTSD. He quoted national experts including Seattle VA psychiatrist Evan Kanter who stated, “We are seeing an increasing number of returnees with classic post-traumatic stress symptoms.... and anxiously waiting for a flood...” (of new clients). ##

# Practice Guidelines for Treating PTSD and ASD

The *American Journal of Psychiatry* periodically publishes practice guidelines for the assessment and treatment of psychiatric disorders. As the editors state, the guidelines are not meant to be considered standards of practice, which are considered locally, given the individual situation. In November 2004 the Journal published its supplement "Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder," [161(11)]. The Guideline was written by a work group which was chaired by Robert Ursano, MD. As they state in their introduction, PTSD has been studied and treated for centuries under various names. Currently, their reading of the research literature estimates the lifetime prevalence of PTSD to be 7.8%, for the general population, with figures much higher for certain populations, such as persons abused as children and war survivors. The Guideline establishes a rationale for the formulation and implementation of a treatment plan, which comprises the heart of the text.

"It is important for this evaluation that specifically assesses for the symptoms of ASD and PTSD, including dissociative, reexperiencing, avoidance/numbing, and hyperarousal symptom clusters and their temporal sequence relative to the trauma (i.e., before versus after 1 month from the traumatic event).... Other important components of the assessment process include functional assessment, determining the availability of basic care resources (e.g., safe housing, social support network, companion care, food, clothing), and identifying traumatic experiences and comorbid physical psychiatric disorders, including depression and substance use disorders..." (p. 4).

The Guideline differs with the review of literature by McNally, et al., [see this *RAQ* page 6] on the issue of whether supportive counseling is helpful. The Guideline states "Encouraging acutely traumatized persons to first rely on their inherent strengths, their existing support networks, and their own judgment may also reduce the need for further intervention.... In populations of patients who have experienced multiple recurrent traumas, there is little evidence to suggest that early supportive care delivered as a stand-alone treatment will result in lasting reductions in PTSD symptoms. However, no evidence suggests that early supportive care is harmful" (p. 5).

The Guideline states that "no controlled studies of psychodynamic psychotherapy, eye movement desensitization and reprocessing (EMDR), or hypnosis have been conducted that would establish data-based evidence of their efficacy as an early or preventive intervention for ASD or PTSD" (p. 6).

The Guideline presents the diagnostic criteria side by side in tables, then presents a definition: "ASD and PTSD are psychiatric disorders consisting of physiological and psychological responses resulting from exposure to an event or events involving death, serious injury, or a threat to physical integrity" (p. 7).

A valuable part of the APA Guideline is its detailed discussion of the requirements for an initial evaluation following a traumatic event. "During the evaluation, the clinician obtains a longitudinal history of all traumatic experiences, including age at time of exposure, duration of exposure (e.g., single episode, recurrent, or ongoing), type of trauma (e.g., motor vehicle accident, natural disaster, physical or sexual assault), relationship between the patient and the perpetrator (in cases of interpersonal violence), and the patient's perception of the effect of these experiences (on self and significant others). Other factors or interventions that may have intensified or mitigated the traumatic response should also be identified" (p. 8). The Guideline cites several checklists and scales to aid in the evaluation process.

The very thorny problem of secondary gain is addressed and the Guideline advocates for a separation between the forensic and treatment roles. As they state, "Determining the temporal course of symptoms relative to the timing of legal initiatives is helpful in this process..." (p. 9).

## Comorbid Disorders

The Guideline addresses the issue of comorbid disorders pointing out that "seriously mentally ill persons also have higher rates of PTSD..." (10), and that "histories of victimization and PTSD are also common among individuals with substance-abuse disorders" (p. 10). Guideline authors note that traumatic histories place persons at a higher risk for an "accentuated response to further traumatic events" (p. 10).

Along with the task of assessing comorbid disorders and the higher risk of PTSD in persons with prior traumas, the Guideline highlights the risk of suicide. "An association has also been observed between the number of previous traumatic events and the likelihood that an individual will attempt suicide..." (p. 11). The authors acknowledge that "it is not possible to predict suicide in a given individual at a given point in time" (p. 10), but note that a number of factors should be explored, e.g., whether the individual has thoughts of death, has engaged in planning and preparation for suicide, and has the means to carry out a plan. They note that those with prior histories of suicide attempts, those with suicide in their family histories, and those who have experienced the suicides of others, are at higher risk for suicide. They also pointed out (p. 11) the lethal risk of someone feeling trapped in an abusive or dangerous situation.

The Guideline addresses treatment settings, emphasizing the patients need to trust clinicians and the treatment process. They ask clinicians to consider referring clients. "The choice of treatment setting and the patients' ability to benefit from a different level of care should be reevaluated on an ongoing basis throughout the course of treatment, as efficacy does not necessarily increase with increasing duration of treatment in a specific setting or level of care..." (p. 11). The authors point out that PTSD presents a problem disorder because "studies have indicated that those with PTSD underuse or avoid mental health

(Continued on page 5, see *Guideline*.)

**(Guideline, Continued from page 4)**

services..." (p. 11). They advocate for patients' control over depth of treatment. "Clinicians must acknowledge the patient's worst fears about reexposure to intolerable traumatic memories and recognize that treatment itself may be perceived as threatening or overly intrusive" (p. 11). And they note the importance of coordination of care with other disciplines, especially physical medicine, as "individuals with PTSD also often have high rates of somatic and somatoform (i.e., medically unexplained) symptoms that are not directly related to the traumatic event but that prompt visits to primary care physicians..." (p. 12).

**Chronic PTSD**

Chronic PTSD, the Guideline notes, requires a different level of care. "For patients who develop chronic PTSD, a long or indefinite duration of treatment may be needed. During acute exacerbations, patients with chronic PTSD may be easily discouraged and unduly pessimistic about their chances of recovery. In addition, the side effects or requirements of treatments may lead to nonadherence. Patients with PTSD who appear to have achieved stable and positive clinical response and those who appear to have recovered from ASD may exhibit sudden relapse when new events reactivate traumatic concerns and fears about the safety of their families or themselves" (p. 13).

**Resilience**

The Guideline authors discuss the topic of resilience in the context of treatment, indicating that resilience refers not only to those who do not get PTSD after a traumatic event, but also those who develop PTSD and learn to tolerate and manage the symptoms. One significant benefit from treatment, they suggest, is the patients' learning to "discriminate trauma cues and reminders from the original traumatic experience(s) by promoting adaptive coping with reexperiencing states and instilling the belief that the current response to triggers results from recall of a past danger that is no longer present" (p. 14). They add that treatment helps patients avoid skewed beliefs about the future and assists them in the search for meaning.

**Treatment**

The Guideline authors summarize their treatment section succinctly. "Since the initial treatment plan will have detailed each selected treatment, the rationale for its use, and the goals for treatment outcome, a review of this initial plan of care should help determine the extent to which therapeutic goals have been met" (p. 15). With or without treatment, "throughout the first 3 months after a traumatic event, recovery is the general rule" (p. 16).

The authors go on to review the various therapies and describe the most effective, namely cognitive behavior therapy combined with pharmacotherapy, psychoeducation and support. They then tackle the issue of comorbid disorders, including the importance of assessing the survivor's history of previous traumas, which they state "may modify vulnerability to subsequent trauma, influence the development of PTSD and complicate treatment and recovery" (p. 22).

The Guideline authors outline several points of psychoeducation. "When access to expert care is limited by environmental conditions or reduced availability of medical resources, rapid dissemination of educational materials may help many persons to deal effectively with subsyndromal manifestations of trauma exposure. Such educational materials often focus on 1) the expected physiological and emotional response to traumatic events, 2) strategies for decreasing secondary or continuous exposure to the traumatic event, 3) stress-reduction techniques such as breathing exercises and physical exercise, 4) the importance of remaining mentally active, 5) the need to concentrate on self-care tasks in the aftermath of trauma, and 6) recommendations for early referral if symptoms persist. Encouraging persons who are acutely traumatized to first rely on their inherent strengths, their existing support networks, and their own judgment may reduce the need for further intervention" (p. 19).

In an observation most applicable to those exposed to combat or physical assault, the Guideline cites Kardiner's post WWI observations, addressing the issue of aggressive behavior as a posttrauma symptom: "More than half-century ago, Kardiner [*The Traumatic Neurosis of War (1948)*] noted that some patients with PTSD had problems with aggressive behavior that was frequently impulsive and episodic. More recent studies have documented increases in domestic violence, child abuse, and delinquency after disasters.... It has been postulated that with the development of PTSD, an increased expectation of danger and potential trauma occurs and results in an 'anticipatory bias'...or an increased readiness for 'flight, fight, or freeze.' This increased readiness for aggression, as well as decreased sleep associated with PTSD, may produce a reduced ability to tolerate mild or moderate slights, resulting in acts of aggression that are disproportionate to the level of provocation..." (p. 22).

The Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder and information about the Practice Guidelines is available from the APA website: [www.psych.org](http://www.psych.org). EE ##

**RAQ Retort**

**The *Journal of Traumatic Stress* doesn't invite comment, but we do. If you find that you have something to add to our articles, either as retort or elaboration, you are invited to communicate via letter or Email. And if you have a workshop or a book experience to tout, rave or warn us about, the RAQ may play a role. Your contributions will make a difference. Email or write to WDVA.**

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## Effects of Early Posttrauma Intervention Examined—Critical Incident Debriefing, Supportive Counseling Found Wanting

In a topic that is very relevant in time of seemingly endless war on terrorism, three authors have produced a much needed review of the questionable utility of early intervention after a traumatic event. Richard McNally, Richard Bryant, and Anke Ehlers published their hearty review in the journal *Psychological Science in the Public Interest* ["Does Early Psychological Intervention Promote Recovery from Posttraumatic Stress?" 2003, 4(2), 45-79]. The authors provide a thorough definition of PTSD and acute stress disorder. They look at research related to risk assessment and prevention of PTSD through psychological debriefing. After examining studies purporting to support debriefing, and those that contend that the method is inert at best and may even be harmful, they advocate instead for a kind of psychological first aid that secures the survivors safety and comfort, and seeks to meet their needs at the moment. They conclude their article with a comprehensive review of cognitive-behavioral therapy during various stages posttraumatic recovery.

True to their thoroughness, Drs. McNally, Bryant and Ehlers conclude their review on the effects of early interventions. "Although psychological debriefing is widely used throughout the world to prevent PTSD, there is no convincing evidence that it does so. RCTs (randomized controlled trials) of individualized debriefing and comparative, nonrandomized studies of group debriefing have failed to confirm the method's efficacy. Some evidence suggests that it may impede natural recovery. For scientific and ethical reasons, professionals should cease compulsory debriefing of trauma-exposed people. In response to the disappointing results for psychological debriefing, crisis intervention specialists recommend psychological first aid, which includes attending to the survivors' individual needs in a nonprescriptive, flexible way" (p. 72). They conclude their discussion of psychological debriefing with a terse comment: "Thus, contrary to widely held belief, pushing people to talk about their feelings and thoughts very soon after a trauma may not be beneficial. Perhaps systematic exposure to the trauma memories should be reserved for people who fail to recover on their own" (p. 66).

McNally and associates are cautiously optimistic about the utility of cognitive behavioral therapy. "The evidence for the efficacy of early CBT treatment in preventing chronic PTSD among symptomatic trauma survivors is mixed, but encouraging. It remains unclear whether CBT given in the first month after trauma is more effective than repeated assessment alone or no intervention..." (p. 72)

They give a nice detailed description of the process employed in cognitive behavioral therapy, quoting Foa and others, and state clearly that cognitive behavioral therapy is

more effective than supportive counseling alone. In fact, they found that supportive counseling "impeded natural recovery" (p. 71) They propose that this may be done by suggesting psychopathology where there is none. "Intense emotional experience," they assert, "is not necessarily indicative of psychopathology" (p. 74).

McNally and associates did not examine other therapies, such as hypnotism alone or eye-movement desensitization as effective therapies in early posttrauma intervention.

### Risk Factors

In their review of research, McNally and associates, using the 9/11 calamity as a touchstone, found that training or already existing support networks precluded the need for most of the extensive offers of counseling support. They write, "Thus, people who are exposed to trauma, but who lack social support, may be at heightened risk for developing PTSD. Stated differently, a supportive posttrauma environment might hasten reduction in acute symptoms, thereby reducing risk for PTSD" (p. 50). The authors also note that higher IQ improves chances of recovery. "Two prospective studies of Vietnam veterans and Israeli soldiers indicate that above-average intelligence may buffer people against the traumatic effects of stressors..... In both studies, higher IQ scores predicted lower risk for PTSD following combat" (p. 51).

Posttrauma symptom severity also predicted later PTSD, not within days, but after 1 to 2 weeks (p. 51). And they observe, "The higher the distress or perceived threat, the more severe PTSD symptoms were likely to be" (p. 52) They note also, apropos the Vietnam War veteran: "Perceived lack of social support is strongly linked to heightened risk for PTSD." And the authors reiterate a finding that is now nearly common knowledge, "Current research indicates that the single most important indicator for the risk of chronic PTSD is the severity of the symptoms" (p. 68).

### Comment

Early intervention following a traumatic event is a pertinent issue in Washington state given the eventual return of veterans from the war in Iraq. Is the young man or woman who drinks too much with friends, stays out late, over-reacts emotionally, etc., behaving any differently than others in young adulthood? When one leaves the military, one leaves an overarching structure and must then proceed alone, and knowing that trauma is in the recent history, how long should one wait for the veteran to adjust? McNally, Bryant, and Ehlers recommend we wait at least one to three months before intervening, and before that, they recommend supportive first aid. EE ##

# *The Interaction of Personality and PTSD*

The issue of how personality interacts with PTSD is an unsettled question. Mark Miller, Ph.D., of the National Center for PTSD and Boston University tackles the subject for the *PTSD Research Quarterly* [2004, 15(3)].

Dr. Miller chooses to limit his discussion of personality to a "Three-Factor Model of Personality." He explains, "Personality traits are generally conceptualized as consistent patterns of thoughts, feelings, and actions across developmental periods and contexts, but personality models differ widely with regard to the factor structure, number, and definition of these traits. This review will focus on three broad dimensions, or higher-order factors, that are particularly relevant to the development and expression of psychopathology: positive emotionality (PEM), negative emotionality (NEM), and constraint (CON). PEM refers to "individual differences in the capacity to experience positive emotions and tendencies towards active involvement in the social and work environments. It is aligned closely with extraversion, includes traits associated with perceived wellbeing, social closeness, social potency, and achievement orientation...." Conversely, NEM "has an orthogonal relationship to PEM and refers to dispositions toward negative mood and emotion and a tendency toward adversarial interactions with others. It is synonymous with neuroticism, subsuming traits relating to anxiety (i.e., stress reaction), alienation, and aggression...." CON refers to an impulsivity dimension involving planfulness, harm avoidance, and traditionalism.

Quoting Paula Schnurr's research, Dr. Miller notes that there is a "significant association between pre-trauma NEM and the subsequent development of PTSD," and he states further that NEM "predicted PTSD severity." He refers to several prospective studies that follow survivors from the time of trauma longitudinally forward and states that "NEM predicted the progression of PTSD." He notes that this predictability was true even after other risk factors such as gender, early parental separation, preexisting anxiety, depression, and parental mental disorder were controlled.

Dr. Miller concludes from his review of research that NEM "is the primary personality risk factor for PTSD following trauma exposure." Furthermore, he sees PEM also as a dimension of personality that is altered "as a consequence of trauma exposure." Low NEM "is associated with emotional stability, the absence of nervousness and anxiety, and the capacity to remain calm in stressful situations and to recover quickly from negative experiences. When these characteristics are combined with sociability, the tendency to take pleasure in and value close interpersonal ties, and the capacity to be warm and affectionate and to turn to others for comfort and help in time of need (i.e., high PEM), the profile that emerges is that of

a personality resilient to stress, loss, adversity, trauma, and the development of psychopathology."

## **Comorbid Disorders**

In his article, Dr. Miller presents a figure displaying the theoretical co-morbid disorders associated with PTSD, and shows how they are connected to high NEM and low PEM, as in the case of schizophrenia, panic, major depression, and generalized anxiety disorders. High NEM and low CON (that is, constraint), clusters such disorders as bulimia, alcohol and substance abuse, antisocial and borderline personality disorders.

Dr. Miller concludes: "This model has potential to link our understanding of psychopathology of PTSD with research on the structure and organization of common mental disorders more broadly. It offers a dimensional framework for understanding individual differences in post-traumatic adjustment, including patterns of comorbidity and their relationship to personality, and it is consonant with the movement towards a dimensional nosology for DSM-V."

## **Comment**

Research and theoretical explorations of personality dimensions in relation to psychopathology run the risk of creating bias. For example, associating pro-social extraversion with resilience makes sense, yet might also offer a rationale for discriminating against introverts in job selection. We have seen elsewhere in the *RAQ* that bias toward PTSD is such that fear of stigma is common. We note also that Dr. Miller confirms that the existence of PTSD has the potential to alter personality, as he says, in lowering the survivor's PEM (positive emotionality).

There is another problem with this kind of theorizing. The presumption, for instance, that a person with high PEM survives trauma without PTSD is based on a kind of bias toward mental health idealism. The high PEM person strikes this reviewer as someone who has lived for most of life in never-never land where trauma, loss, and perversion do not exist insofar as they affect one's personality. Perhaps high PEM in fact measures something like the lucky minority who have thus far been impervious to trauma, and for whom the measured traumatic experience in the study is their first time through the maze. The old fashioned concept of ego strength seems spookily similar to high PEM. It's been a given that one is better off going into combat coming from a good home and solid family. Yet, given the exigencies of prolonged combat, anybody may succumb to PTSD. And then, what happens? One loses PEM, sure enough. EE ##

# The Cultural Changes of PTSD Since World War II

The *New Yorker* magazine again has an article addressing the cultural issue of PTSD. In the "Annals of Psychology" section, author Malcolm Gladwell gives us "Getting Over It: The Man in the Gray Flannel Suit put the war behind him. What's Changed?" [November 8, 2004, 75-79], completely misinterpreting his subject matter. He compares two novels about different wars: *The Man in the Gray Flannel Suit*, by Sloan Wilson, (1955), about a World War II combat veteran Tom Rath, and Tim O'Brien's *The Lake in the Woods* (1994), about a Vietnam War veteran, John Wade. Mr. Gladwell compares the two novels as characteristic of their respective generations. His thesis, oddly, is that one got over it, and the other didn't. Odd because Tom Rath was a man caught in the throes of PTSD. His alcohol abuse, excused as a generational thing, his flashbacks on the train, and his intrusive thoughts were accompanied by memories of his affair with an Italian woman in Rome during his leave between war theaters, when he was convinced that he would soon die.

Mr. Gladwell takes Tom Rath, in Sloan's novel, as an example of a combat veteran with post-war adjustment challenges who ends up "stronger, and his marriage renewed." In contrast, Mr. Gladwell shows us that O'Brien's Wade is destroyed. He writes, "This is the difference between a novel written in the middle of the last century and a novel written at the end of the century. Somehow in the intervening decades our understanding of what it means to experience a traumatic event has changed. We believe in John Wade now, not Tom Rath, and half a century after the publication of 'The Man in the Gray Flannel Suit' it's worth wondering whether we've got it right" (p. 76).

Mr. Gladwell cannot seem to see that alcohol abuse was an eventually destructive way to cope with posttraumatic symptoms, such as displayed by Tom Rath. The awareness that alcohol was destructive was then at the same level of collective understanding as tobacco smoking.

*The Man in the Gray Flannel Suit* is an excellent example of how the psychological sequelae of trauma includes non traumatic events in its symptom expression. Tom Rath, engages in an adulterous love affair after having been traumatized in the Battle of the Bulge and while awaiting reassignment to the Pacific Theater, where he is convinced that he will die. What he does as the result of this belief is what he struggles with years later.

Right or wrong, Mr. Gladwell then takes a turn in an odd direction. He departs from the issue of war veterans and looks at childhood sexual abuse, citing a *Psychological Bulletin* article [the reference was not

cited, but the authors were said to be Bruce Rind, Robert Bauserman, and Philip Tromovitch] in essence saying that sexual abuse was at worst marginally damaging. This he takes to be evidence that trauma is not so damaging. This finding, the author observed, was vilified in the press as unacceptable, yet was evidence that trauma was something one can get over. He states his thesis thus: "Once you've separated a small number of seriously damaged people—the balance of C.S.A. (child sexual abuse) survivors are pretty much going to be fine" (p. 78). David Spiegel of Stanford U. responded in the Dec. 6 issue in a letter noting the limited range of the cited research (p. 12), sampling only college students, "who by definition were resilient enough to make it to higher education."

Mr. Gladwell then turns to research on people who get over the deaths of spouses and get on with their lives. It was certainly true then and is now that most people involved in traumatic events are not afflicted with posttraumatic stress disorder, but instead recover from the peritraumatic and early posttraumatic symptoms and return to normal, although it is doubtful that one ever returns to normal after a traumatic event.

What he fails to observe is that what happened in the years intervening between the two novels was a raising of collective consciousness with the introduction in 1980 of a defined disorder that describes posttraumatic impairment. Following the new diagnostic category of PTSD came a parade of research that has measured the way people recover from traumatic events. None of this awareness was available after WWII.

Furthermore, Mr. Gladwell compares different groups with different circumstances when he compares childhood sexual abuse survivors to combat traumatized veterans. The flaw in the comparison is first with the age of the trauma onset and the reliable adaptive resilience of children. The facts are that a minority of child sexual abuse victims remain impaired all their lives, showing sometimes tragic maladaptations. Combat, we know, also results in a minority of veterans being afflicted with PTSD.

We've had the advantage now of 25 years of research and clinical experience regarding PTSD. We recognize the symptoms and the life-long suffering that combat veterans endure. We have a collective understanding that while most people are thankfully resilient, each traumatic situation is a new stressor to be endured. That some sexual abuse situations are not permanently damaging, is to say no more than what is true for almost every traumatic encounter. However, it is also true that repeated exposure to traumatic events increases the odds the posttraumatic stress disorder will set in.

It is unfortunate that Mr. Gladwell appears to misunderstand the epidemiological literature of PTSD, because the issue of the changes in culture changing collective regard for PTSD is an important topic. EE ##

# Fear of Stigma Reduces Mental Health Care Utilization

The problems caused by stigma associated with posttraumatic stress disorder occur both inside the military and in civilian life for the veteran. The problems are manifested in surveys and statements of soldiers and marines returning from combat. The only ones who admitted having PTSD symptoms, it was believed, were the ones who were malingering, which is consistent with the belief that being diagnosed with PTSD meant the end of ambition in the military.

Patrick Corrigan, writing in the October *American Psychologist* [2004, 59(7), 614-625, "How Stigma Interferes With Mental Health Care"], makes a distinction between what he termed "public stigma" and "self stigma" (p. 616), referring to the beliefs and superstitions one might harbor about the disorder. He defines self stigma as "what members of a stigmatized group may do to themselves when they internalize the public stigma." Dr. Corrigan, who is a psychologist at the University of Chicago, confirms that the fear of stigma expressed in the surveys of veterans returning from Afghanistan and Iraq [see *RAQ* 2004, 9(1)] are also found in the general public. Dr. Corrigan cited research showing that only 30-40% those with mental illness seek treatment (p. 615). One reason he gives for this is "label avoidance" (p. 615). "Endorsing negative attitudes about mental illness inhibits personal service utilization in those at risk for psychiatric disorder" (p. 617).

Dr. Corrigan refers to shame in the process of label avoidance, but it seems that among returning veterans there must also be a very strong wish that they will be all right and in due time they'll get over it. They put off admitting to PTSD symptoms the way many people put off taking sick leave or calling the doctor just because they have a few symptoms of illness. We trust nature, we trust our own resilient immune system, which reflects the inertia of our healthy self image.

Dr. Corrigan does not really define stigma. He writes that "the stigma process is proffered as one relevant factor [why people with mental health problems fail to engage in treatment] and is framed here as four social-cognitive processes: cues, stereotypes, prejudice, and discrimination" (p. 615). Webster defines stigma as a scar, mark of shame or discredit, a diagnostic sign of disease, a brand.

Cues that Dr. Corrigan refers to might come from the startle response, which frequently elicits shame, or from the shame of tearfulness, loss of composure, in which the veteran feels he or she "broke down" or "lost it", etc. Or from the tension and anxiety created by sleep deprivation. These symptoms may be interpreted as signs of weakness, loss of composure, suggesting that someone may not be trusted when needed.

Discrimination, with regard to PTSD, comes when one chooses *not* to file a claim with the VA because the label is then applied. One is "service connected for PTSD," i.e., certified, to be thereafter noted on job applications, insurance applications, and performance evaluations. Dr. Corrigan writes that "approximately one third of the 50 states restrict the rights

of an individual with mental illness to hold elective office, participate on juries, and vote..." (p. 621) and "about 50% of states restrict the child custody rights of parents with mental illness." Dr. Corrigan refers to this as "structural sigma; namely economic and political pressures on the culture, rather than psychological influences in the individual, that yield discrimination and undermine care access" (p. 620).

That the stigma exists, then, is well established, both as self stigma, that is, personal beliefs that inhibit one from seeking treatment, and public stigma, in the form of institutional discrimination and collective beliefs. This is not the same as FDR having polio or JFK having a bad back. The stigma of PTSD is the belief that one's character has been weakened and that one is more vulnerable to acquiring other disorders or to losing composure. The problem with dispelling such prejudices is that examples of persons with PTSD who continue to perform and behave normally are not well known. Many high performing people with PTSD, who would otherwise serve to dispell the prejudice, keep the disorder a secret *because* of the stigma. There is no equivalent in PTSD to the major league ball players who pitch with a diabetes insulin feeder, or who pitch with one hand missing, or who play NBA basketball with HIV.

It appears that the only way to combat stereotype is to march before the troops high ranking or high profile examples of persons with PTSD who can testify to the successful management of the disorder, who can do what is often done in veterans' groups—normalize the condition. And there is always the bully pulpit of high office that could shame the insurance companies and businesses for not being patriotic and sharing the sacrifice of war.

Perhaps in other, more war damaged countries, the general populace is more tolerant of PTSD symptoms. I am thinking here of a humorous scene in the German film, *The Marriage of Maria Braun*, which takes place amid the rubble of a recently bombed city, at a public kitchen, where every time there is a loud noise, *everybody* dives to the floor. In the U.S.A., however, despite the heightened awareness regarding terror, there is still a large majority who comprise public opinion who regard PTSD with the same stigma that they apply to major mental illness.

What the federal VA can do is more education. We need another Bob Dole to come forth and destigmatize PTSD the way he destigmatized erectile dysfunction. If the pharmaceutical companies are willing to invest in that kind of advertising, it must mean it is possible to change public attitude toward common health problems. The facts indicate that the sooner someone seeks treatment for PTSD, the less chance there is for bad habits to form around misdirected coping strategies and the less chance there is for PTSD to be transmitted directly through abuse of others, or indirectly through the intergenerational passing on of guilt and prejudice, and perhaps most importantly, the sooner one can avoid the social alienation that accumulates over time, like a roadway littered with unfortunate encounters.

EE ##

Movie Review:

# *Open Range*: “I’m trying to put some bad things behind me, but they keep coming up.”

Reviewed by Emmett Early

As a child of the 1940s, I lived for the Western movie each Saturday matinee at the Tamalpais Theater, where I could see such cowboy stars as Gene Autry, Tim Holt, and Hopalong Cassidy. Radio, too, gave me Westerns: Cisco Kid, Red Rider, The Lone Ranger. Then came *Shane* (1953), the thoughtful Western about the gunfighter who wanted to quit, and then Sam Peckinpah changed the Hollywood Westerns forever with *The Wild Bunch* (1969) by attaching realistic suffering, bloody wounds, fear, and ugliness to killing. He was followed in 1971 by Robert Altman, who played havoc with the Western genre with the Oregon frontier drama *McCabe and Mrs. Miller*. Now, next century, we have PTSD, which is what ordinary folks get when they have to kill, and gritty, bitter Westerns featuring old gunfighters trying to retire, as in Clint Eastwood’s *The Unforgiven*.

Kevin Costner directed *Open Range* with an expressed love for the cowboy character. Released in 2004, *Open Range* has all the Western that Zane Gray and John Ford could muster. It features a group of four men who are driving a herd of cattle and run afoul a powerful rancher who would rid the land of the “free grazers.” The rancher, an Irish immigrant, controls the sheriff and owns the town tavern. In a series of assaults, the rancher’s men shoot Button, the “boy” who drove the wagon, and Mose, the big simple guy who helped with the herd. The remaining free grazers seek revenge: they are Boss, Robert Duvall, and Charlie, Kevin Costner. They are helped by the town Doctor, Doc Barlow, and his sister, Susan (Annett Benning), a “real lady,” who treat their friends’ wounds.

### Colorful Lines

*Open Range* is marked by sparse, colorful dialog. Directed by James Muro, with screenplay by Craig Storpon. The lines are to be savored.

“Let’s rustle up some grub.”

“Old Boss sure can cowboy.”

“We’ll drink to good health to them that has it coming.”

“We sure as hell owe ’em for what they done to Mose.”

Costner’s character, Charlie, is a veteran of the Civil War. When Mose is killed and Button is brought near death, both Boss and Charlie agree on what they have to do. Charlie says, “I got no problem with killin’, Boss.

Never have.” Yet later he says to Sue, “I’m trying to put some bad things behind me, but they keep coming up.”

Charlie confesses at night to Boss as they lay on the ground under the stars that he learned to kill in the army and “those with the knack make trouble.” He has a nightmare while dozing in the doctor’s office and nearly kills Sue Barlow. “There’s things that gnaw at a man worse than dying.”

The final shootout is in a series of vista shots that stumbles all over town. Charlie tells Sue, ruefully: “Men are going to get killed here today, and I’m going to do the killing.” In the end, Charlie’s proposal of marriage is accepted by Sue Barlow, knowing he is a good man as well as a killer.

Costner and Duvall are successful portraying two “rough old dogs,” who find nicety and comfort awkward, who are bound by duty and a sense of justice, and who in the end are just a little tougher than the bad guys. Both men are driven by duty to avenge the death of Mose and injuries done to their friends. There is a broad, simple ethos that incorporates killing as a part of natural justice. No one seems to blink at the concept that law enforcement is up to themselves.

### The Cultural Clash

The theme runs through *Open Range* like a meandering river giving a very traditional form that Westerns take describing the cultural clash of the corporate commerce with individual free enterprise. *Open Range* depicts a microcosm that gives us a view from a distance of our own struggles. The same tension we can see existing these days in the encroachment of so-called managed care corporation telling the private practitioner how much he can charge and when. It could as well be the big rancher saying to the free grazer, “this here’s my land now and you got to have my permission to cross it.”

In the merry days of yore, when I paid a 25 cents to see gunfights at the Tamalpais Theater, there was a choreographed quality to the dramas. Blows were cleanly thrown, whiskey was tossed down like apple juice. Men performed feats of horsemanship and the streets were clean of dung. The frontier life was romantic and victims seldom bled.

The introduction of ugliness and suffering with death was a gradual evolution in Hollywood that for me seems to accompany the aging process. Good and evil survive less clearly now. Boss and Charlie would be sent to anger management and told not to shout at the receptionist. ##

**Film Review:*****The Chase: An Innocent Navy Veteran is Caught up in Crime***

Reviewed by Emmett Early

One of the classic film *noir* themes, one that Alfred Hitchcock exploited to great art, was the trials of the innocent man who is caught up in crime while trying to do the right thing. An interesting twist to this theme is in the recently restored 1946 *noir* film, *The Chase*. Robert Cummings, who we later saw in sitcom, was the right casting for an innocent WWII navy veteran who is out of work and hungry. We see him watching a restaurant fry cook at work serving up bacon and eggs. He is obviously unable to afford such a meal. As he gawks through the restaurant window, he steps on a wallet. There are lots of big bills in the wallet and a card in the wallet indicates the owner. Our hungry man has breakfast on his benefactor and then goes to look him up to return the wallet. Unfortunately for our protagonist, the owner of the wallet is a cruel big-shot named Eddy Romand (Steve Cochran), assisted by his tough and cynical sidekick, played by Peter Lorre. Cummings' naive ex-sailor introduces himself as Chuck Scott.

*The Chase* is directed by Arthur Ripley from a novel, *The Black Path of Fear*, by Cornell Wollrich, adapted to the screen by Philip Yordan. The plot is rather complicated. Chuck is hired as a driver by Eddy, who is impressed by the man's simple honesty. Chuck is a veteran of the navy, and we learn soon that he has been under the care of a doctor at the navy hospital. Chuck's job includes driving Eddy's wife, Lorna, played by Michele Morgan, who is demeaned by Eddy. We are introduced to Eddy and get an immediate sense of his style when he slaps a manicurist and has his dog kill a business competitor trapped in his wine cellar.

**Chuck's Fantasy**

Eddy's wife, Lorna, expresses her desire to Chuck, revealing that she wants to flee on a ship to Cuba. Chuck arranges the passages and seems to take her there while she is followed and finally murdered by Eddy's agents. However, we realize that Chuck has flights of fantasy and the trip hasn't happened as it seemed, as we watch the flight of Chuck and Mrs. Roman a second time, this time for real.

Chuck's doctor gets involved. When Chuck confesses his confused state, saying that "I keep feeling that there's something I need to do," the doctor assures him that this is normal for shock cases. The doc declares that Chuck is suffering from anxiety neurosis.

**The Post-War Mood**

One of the chief ingredients in *noir* thrillers is the reliance on shadow and darkness, as if everybody lived

in the path of a storm that was lingering on the horizon. The Great Depression was interrupted by World War II and the *noir* motif of treachery and deception, heartless brutality and meanness marked cinema through the 1950s. A great symbol of helplessness when driven by a bad mood comes in *The Chase* in the repeating action scenes in which the gangster, Eddy Romand, activates the automobile's accelerator from the back seat, locking out the controls of the driver. This makes for a couple of hair-raising races with trains.

In Chuck's fantasy escape with Mrs. Romand he is accused of her murder when she is stabbed in a Havana bistro while dancing with Chuck, and Chuck's recently purchased knife is the murder weapon. Police pursue the truth with persistent investigation, but it is all moot when we learn that these scenes of guilt and punishment are taking place only in the veteran's mind. We never know why—was it something that happened to Chuck in the war?

**Guilt and Accusation**

Cummings plays the navy veteran as innocent and troubled, evidently by a denial of pathology. The trick is that we are tricked by the flow of the drama into thinking that what we are seeing is really happening. The gist of Chuck's "dream" is that he falls in love with a woman who is murdered and he is accused convincingly of being the killer. She is murdered in the midst of a long romantic scene that flows into a colorful Cuban nightclub. The scene turns abruptly into guilt and accusation. Then we learn from the navy doctor that Chuck's condition was "normal for a shock case."

The Hitchcockian theme of the normal, innocent guy caught up in madness and evil applies to those who bite off more than we can chew, or perhaps, as in the case of many a war veteran and Depression victim, get bitten by the chewer. The veteran responds to Mrs. Romand's appeal, and then is struck by his own "anxiety neurosis" that would prohibit him from enjoying the fruits of his adventure.

*The Chase* was restored to a tolerable condition, along with a second feature on a recently released "classic *noir*" cd. Reminds me of the olden days of cinema when we went to double features in which an "A" film was billed with a more cheaply produced "B" movie that we wouldn't pay to see otherwise.

*The Chase* is murky. If what we see is restored, it must have been very badly damaged to begin with. Some scenes are discontinuous, others are oppressively sappy with romanticism. Peter Lorre, cigarette hanging jauntily from his lips, just about steals the show as Romand's psychopathic assistant. ##

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## King County Veterans Program offers trauma counseling services to veterans and family members under contract with the WDVA PTSD Program.

KCVP also provides vocational counseling, emergency assistance, and other services, and is located at 123 Third Ave. S., Seattle, WA.  
 Telephone: 206 296 7565.  
 Joel Estey, Director, KCVP

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To be considered for service by a WDVA or King County contractor, a veteran or veteran's family member must present a copy of the veteran's discharge form DD-214 that will be kept in the contractor's file as part of the case documentation. Occasionally, other documentation may be used to prove the veteran's military service.

It is generally preferred that the referring person telephone ahead to discuss the client's appropriateness and the availability of time on the counselor's calendar. Contractors are on a monthly budget, however, contractors in all areas of the state are willing to discuss treatment planning.

Some of the program contractors conduct both group and individual/family counseling. Family members of war deployed Military Reserves and Washington State National Guard are also eligible for these services. Veterans of any of our nation's wars or peace keeping actions, OIF, OEF, Global War on Terror, women veterans, or minority veterans are encouraged to contact Tom Schumacher, Program Director, for assistance or referral.

*The Repetition & Avoidance Quarterly* is published each season of the year by The Washington Veterans PTSD Program, of the Washington Department of Veterans Affairs. The PTSD program's director is Tom Schumacher. The editor of the *RAQ* is Emmett Early. It is intended as a contractors' newsletter for the communication of information relevant to the treatment of PTSD in war veterans and their families. Your written or graphic contribution to the PTSD Program newsletter is welcomed if it is signed, civilized, and related to our favorite topics of PTSD and war veterans. Contributions may be sent by mail to the Washington Department of Veterans Affairs (Attn: Tom Schumacher), PO Box 41150, Olympia, WA 98504, or by Email directly to <emmett@dva.wa.gov>. Readers are also invited to send in topical research or theoretical articles for the editorial staff to review. Comments on items reported in the *RAQ* are also encouraged and will likely be published if they are signed. To be included in our mailing list, contact WDVA, Tom Schumacher, or Emmett Early. The *RAQ* can also be read online by going to [www.dva.wa.gov](http://www.dva.wa.gov) Once in the WDVA Website, click on PTSD, and once on the PTSD page, scroll to where you find access to the *RAQ*. The newsletter logo is a computerized drawing of a photograph of a discarded sign, circa 1980, found in a dump outside the La Push Ocean Park Resort. ##